Reply

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Reply

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I thank Dr. Evans et al. [1] for their comments on my invited commentary [2]. The issues they raised give me the opportunity to further discuss some aspects. The reported incidence of parastomal hernia ranges widely from 5 to 65%. Such a large range always indicates some methodologic shortcomings, e.g., no standardized assessment and definitions, various follow-up time, and heterogeneous patient groups. In particular, for the current problem most data originate from small and retrospective series that were published during the 1980s and early 1990s. One must also take into account that probably not all patients with parastomal hernia will contact the responsible surgeon, or these mostly elderly patients are not admitted for surgical treatment due to their age and comorbidities. This is also well known to occur for other diseases, e.g., patients with a Hartmann situation due a perforated sigmoid diverticulitis, where up to 30% of patients never undergo restoration of bowel continuity. As a consequence, the true incidence and clinically relevant numbers of parastomal hernia remain unknown, but it can be assumed that the problem is largely underestimated. Therefore, the proposed estimation that only a minority of patients will develop symptomatic parastomal hernia does not represent the clinical reality.

The study published by Janes et al. [3] is the only randomized trial with a long-term follow-up of 5 years and it provides new insights in this common clinical problem. If we believe in evidence-based medicine, such studies—even if the overall patient number is limited—must be considered to influence our daily surgical practice. It remains to be discussed what is the best mesh to use and where it has to be placed to avoid mesh-related complications.

References

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